Acronyms and terms

Acronyms

ADL	activity of daily living
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
AMC	academic medical center
APR-DRG	all patient refined diagnosis related group
ASC	ambulatory surgical center
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
CAH	critical access hospital
CAHPS	Consumer Assessment of Health Plans Study
CAPD	continuous ambulatory peritoneal dialysis
CAT	computerized automated tomography
CBO	Congressional Budget Office
CC	complication and/or comorbidity
CCI	Correct Coding Initiative
CCPC	Correct Coding Policy Committee
CCPD	continuous cycling peritoneal dialysis
CES	Consumer Expenditure Survey
CHIP	Children's Health Insurance Program
CMI	case-mix index
COTS	commercial off-the-shelf
CPI-U	consumer price index for urban consumers
CPT	Current Procedural Terminology
CVA	cerebrovascular accident
DME	durable medical equipment OR direct medical education
DRG	diagnosis related group
DSH	disproportionate share hospital
E&M	evaluation and management
ESRD	end-stage renal disease
FFS	fee-for-service
FIM	Functional Independence Measure
FIM–FRG	Functional Independence Measure–Functional Related Group
FTE	full-time equivalent
FY	fiscal year
GAO	General Accounting Office
GDP	gross domestic product
GI	gastrointestinal
GME	graduate medical education
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HEDIS	Health Plan Employer Data and Information Set
HHA	home health agency

HHRG	Home Health Resource Group
HMO	health maintenance organization
IME	indirect costs of medical education
IPS	interim payment system
LTC	long-term care
M+C	Medicare+Choice
MCBS	Medicare Current Beneficiary Survey
MCO	managed care organization
MDS	minimum data set
MDS–PAC	minimum data set–post-acute care
MedPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MRI	magnetic resonance imaging
MSA	medical savings account
NF	nursing facility
OACT	Office of the Actuary (HCFA)
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of the Inspector General
OPD	outpatient department
PACE	Program of All-Inclusive Care for the Elderly
PEP	partial episode payment
PIP	principal inpatient diagnosis
PIP–DCG	principal inpatient diagnosis–diagnosis cost group
PPO	preferred provider organization
PPRC	Physician Payment Review Commission
PPS	prospective payment system
PRO	peer review organization
ProPAC	Prospective Payment Assessment Commission
PSO	provider sponsored organization
PT	physical therapy
QISMC	Quality Improvement System for Managed Care
RUC	Relative Value Scale Update Committee
RUG-III	Resource Utilization Groups, Version III
RVUs	relative value units
S&TA	scientific and technological advances
SGR	sustainable growth rate
SNF	skilled nursing facility
SSI	Supplemental Security Income
UDSMR	Uniform Data System for Medical Rehabilitation
USRDS	U.S. Renal Data System

Terms

adjustments to payment rates
Payment systems usually include adjustments to the base payment rates designed to allow for differences in providers' circumstances that are expected to affect their costs of furnishing care. Payment rates may be adjusted, for instance, to accommodate differences in local prices for inputs, which may account for more than 50 percent of the observed variation in providers' costs for a given product or service. Other adjustments may be made to reflect unusual circumstances, such as delivery of specialized types of care or atypical characteristics of beneficiaries. (See base payment amount.)

base payment amount
The base payment amount in a payment system is the amount that a purchaser commits to pay providers for a standard unit of service or product furnished to a covered beneficiary. The base payment amount corresponds to a payment system's unit of payment, which may be individual services, bundles of services (such as hospital stays), episodes of care, or specified periods of time. Providers' payment rates for individual services or products are determined by applying two types of adjustments to the base payment amount. One is based on a relative weight designed to measure the expected relative costliness of each distinct service or product, compared with the cost of the average unit. The other type of adjustment is designed to reflect differences in providers' circumstances that are likely to affect their costs of furnishing care. The base payment amount (sometimes called a conversion factor) thus determines the level of the payment rates in the payment system. (See adjustments to payment rates, relative weights.)

capitation
A payment method in which a purchaser pays a health care entity or provider a fixed amount per person, per time period to supply covered health services to beneficiaries during the period. Contracting entities or providers take the risk that the cost of the covered services beneficiaries use may exceed the capitation payment; if costs are less than the capitation amount, they keep the difference. Employers, government programs, or other purchasers may use capitation to pay health plans, or plans may use it to pay providers. (See fee-for-service, Medicare+Choice.)

case mix
The generic term used to describe the mix of services or products furnished by a provider or group of providers, such as physicians, hospitals, nursing homes, or home health agencies. Providers' case mix is usually summarized by measuring the average expected relative costliness of the services or products provided, which is based on two components. One is a service or product classification system—such as the HCFA Common Procedure Coding System; diagnosis related groups; Resource Utilization Groups, version III; or Home Health Resource Groups—used to identify distinct services or products providers may furnish. The second is a set of relative weights representing the expected relative costliness of the services or products in each classification category, compared with the cost of the average service or product. (See case-mix index, classification system, relative weights.)

case-mix index
Measures the average expected relative costliness of the mix of services or products furnished by a provider or group of providers. The average is calculated by multiplying the number of units supplied in each classification category by the relative weight for the category, adding the results across all categories, and dividing by the total number of units across all categories. (See case mix, classification system, relative weights.)

classification system
Provides the foundation for payment systems by identifying distinct services or products that will be priced separately because they are expected to require different amounts of providers' resources. Each payment system has a classification system that corresponds to the payment system's unit of payment (services, episodes of care, and so on). Examples include the HCFA Common Procedure Coding System used in the physician fee schedule and the diagnosis related groups patient classification system used in the hospital inpatient prospective payment system. (See case mix, case-mix index, relative weights.)

cost-based reimbursement
The method Medicare initially used to pay health care facilities—such as hospitals, skilled nursing facilities, and home health agencies—for services furnished to beneficiaries. Payment was based on providers' costs as reported on annual cost reports, which identified incurred costs by type of service, separated allowable costs reasonably related to the provision of patient care from those attributable to unrelated activities, and distinguished costs related to services furnished to Medicare patients from those incurred for others.

fee-for-service
A method of paying health care providers for individual medical services, as opposed to paying them salaries or capitated payments. Payments may be prospectively determined or based on providers' costs or charges. (See capitation.)

hospital insurance trust fund
The trust fund finances services covered under Medicare Part A. Its primary source of income is payroll taxes paid by employees and employers. (See supplementary Medical Insurance trust fund.)

major teaching hospital
A hospital with an approved graduate medical education program and a ratio of interns and residents to beds of 25 percent or greater.

market basket index
A price index designed to measure prices for the typical mix of goods and services providers purchase to produce a specific product or set of products relative to a base year. Generally, these indexes contain three elements: a set of input categories, such as labor, supplies, and purchased services; a set of price proxies representing the price levels for the input categories; and a fixed set of weights (proportions) representing the relative importance of each input category in providers' input expenditures for the base year. The actual or projected values of the price proxies for a year are multiplied by the category weights and summed to obtain the overall market basket index value for the year. The rate of change in input prices can be calculated by comparing index values over time. HCFA computes separate market basket indexes for most facilities; it also calculates a similar measure, called the Medicare Economic Index, for physicians' office practices. (See update.)

Medicare
A health insurance program for people who are older than 65, eligible for Social Security disability payments, or who need kidney dialysis or a transplant. (See Medicare Part A, Medicare Part B.)

Medicare Part A
Also called hospital insurance. This part of the Medicare program covers the cost of hospital and related post-hospital services, including some care provided by skilled nursing facilities and home health agencies. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries are responsible for an initial hospital deductible per spell of illness and for copayments for some services.

Medicare Part B
Also called supplementary medical insurance. This part of the Medicare program covers the cost of physicians' services, outpatient laboratory and X-ray tests, durable medical equipment, outpatient hospital care, some home health care, and certain other services. The voluntary program requires payment of a monthly premium, which covers 25 percent of program costs, with general tax revenues covering the rest. Beneficiaries are responsible for an annual deductible and coinsurance payments for most covered services.

Medicare+Choice
A program created by the Balanced Budget Act of 1997 to replace the methods Medicare previously used to pay health maintenance organizations (HMOs). Beneficiaries have the choice to enroll in a Medicare+Choice plan or to remain in the traditional Medicare program. Medicare+Choice plans may include coordinated care plans (HMOs, preferred-provider organizations, or plans offered by provider-sponsored organizations), private fee-for-service plans, or high-deductible plans with medical savings accounts.

Medigap insurance
Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles and coinsurance, as well as payment for services not covered by Medicare. Medigap insurance policies must conform to 1 of 10 federally standardized benefit packages.

other teaching hospital
A hospital with an approved graduate medical education program and a ratio of interns and residents to beds of less than 25 percent.

payment-to-cost ratio
A measure that compares providers' payments to their costs. For Medicare, calculated by dividing Medicare payments by Medicare-allowable costs.

productivity
Refers to the quantity of resources used to produce a unit of output. Increased productivity implies that an organization is producing more output with the same resources or the same output with less resources.

prospective payment
A method of paying health care providers in which payments are based on predetermined rates and are unaffected by providers' incurred costs or posted charges. Examples include Medicare's per-discharge payments for inpatient hospital care and the program's per-service payments for physician services.

relative weights
In payment systems, relative weights are used with product classification systems to adjust payment rates to reflect the expected relative costliness of each service or product, compared with the cost of the average service unit. In Medicare's hospital inpatient prospective payment system, hospitals' base payment amounts for cases in each diagnosis related group (DRG) are determined by multiplying their base per discharge payment amounts by the relative weight for the DRG. Relative weights may be based on providers' national average charges or costs for cases in each product category. When charge or cost data are unavailable, weights may be based on judgments by clinicians or other experts, as are the relative values for the professional component of the Medicare physician fee schedule. (See base payment amount, case mix, case-mix index, classification system.)

risk adjustment
The process used to adjust plan or provider payments to account for predictable differences in the cost of providing care to beneficiaries. Risk adjustment is based on the empirical relationship between the cost of providing care and beneficiaries' characteristics, including health status, use of services, and demographic characteristics.

risk score
A measure of the expected costliness of a beneficiary with specific characteristics, compared with the cost of caring for the average beneficiary. For example, if the average cost of caring for beneficiaries is represented by a risk score of 1, then the expected costliness of caring for a beneficiary with a risk score of 1.2 is 20 percent higher. (See relative weight, risk adjustment.)

risk selection
Any situation in which health plans differ in the average health risk associated with their enrollees because of enrollment choices made by the plans or enrollees. When risk selection occurs, health plans' expected costs differ because of underlying differences in their enrolled populations.

standardization
A process of adjusting charges or costs for particular services or bundles of services to remove differences that result from geographic variation in price levels, demographic characteristics, beneficiary health risk, and other factors. Standardization is intended to make charges or costs more comparable among providers, plans, and geographic areas. (See adjustments to payments.)

supplementary medical insurance trust fund
Finances services covered under Medicare Part B. This trust fund is financed from general revenues and premiums paid by beneficiaries. The premium rate is derived annually based on the projected costs of the program for the coming year. (See hospital insurance trust fund.)

update
A periodic adjustment (usually annual) designed to raise or lower a base payment amount to account for the effects of anticipated changes in factors that affect the costs that efficient providers would be expected to incur in providing care. (See market basket index.)

uncompensated care
Care provided by hospitals or other providers that is not paid for directly (by the patient or by a government or private insurance program). It includes charity care, which is furnished without the expectation of payment, and bad debts, for which the provider has made an unsuccessful effort to collect payment due.